Initial Health Assessment

Client Name		**MSSP #**	
Assessment Date		**Staff Code**	
Staff Signature/Title			

Diagnosis/Medical History

What are the client's diagnoses?

What is the client's medical history?

What is the client's rating of his/her own health?

☐ Poor	☐ Fair	☐ Good	☐ Excellent

Has client been in a hospital, SNF or ER in past year?	☐ No	☐ Yes

If Yes, provide approximate date(s) and reason(s):

Medications

Pharmacy used:

☐ Allergies to medications	☐ Forgets medications	☐ Problem with cost
☐ Medications prescribed are covered by Medicare	☐ Has prescription medications in stock which are no longer prescribed	

☐ Primary physician knows about all of client's medications

☐ Does client have help with medications?	☐ No	☐ Yes

If yes, who helps?

What kind of help?

Medications continued

Is more help with medications needed?	☐ No	☐ Yes
If yes, describe:		
Comments S/O		

Nutritional Assessment

Y = Yes	N = No	D = Deferred
Include in your assessment:		
• Usual eating		
• Diet patterns		
• Preparation of meals		
• Shopping		
• Finances		
• Allergies		
☐ Weight loss or gain in past year:		
☐ Special diet/restricted foods:		
☐ Client follows diet:		
Client's appetite (subjective):		
☐ Good	☐ Fair	☐ Poor

Meals per day:	☐ 1	☐ 2	☐ 3

Assessment of client's diet quality (objective):		
☐ Good	☐ Fair	☐ Poor
Nutritional Supplements?		
Approximate amount/type of fluid intake:		
Comments S/O		

Health Habits		
Y = Yes	N = No	D = Deferred
Describe usual use patterns and significant changes:		
☐ Tobacco	☐ Caffeine	☐ Alcohol
☐ HX of alcohol/drug abuse	Sleep pattern	
Comments S/O		

Review of Systems	
Instructions: Check each condition identified by client or observed during the assessment. Inquire about each area as appropriate, and enter response or indicate if not a problem. It is necessary to record a response to each condition. Comments should include changes and impact of condition on function.	
S=Subjective	O=Objective
Eyes/Ears/Mouth	
Eyes	
☐ Glasses or contact lens	☐ Trouble with vision
☐ Change in vision in last year	
Comments S/O	
Ears	
☐ Trouble with hearing	☐ Wears a hearing aid
Comments S/O	
Mouth	
☐ Problems with teeth/gums	☐ Dentures
☐ Problems with dentures	☐ Dentures fit well
Comments S/O	
Respiratory/Pulmonary	
☐ Short of breath	☐ Uses oxygen
☐ Coughs frequently	☐ DX of tuberculosis
Comments S/O	
Cardiovascular	
☐ Pain, tightness, or pressure in chest, neck, or arms	
☐ Swelling of feet or ankles	
☐ Prop pillows at night for shortness of breath	
☐ Fainting/blackouts	

☐ Rapid, irregular, or skipped heartbeats		
☐ High blood pressure		
☐ Cramps in leg muscles	☐When walking	☐When not walking
Comments S/O		

Breasts				
☐ Lumps				
☐ Mammogram	Approximate Date			
☐ Performs breast self-exam				
Comments S/O				

Gastrointestinal		
☐ Trouble swallowing	☐ Indigestion/heartburn	☐ Nausea/vomiting
☐ Constipation	☐ Change in bowel habits	☐ Loose stools or diarrhea
☐ Blood from rectum	☐ Bowel incontinence	☐ Black or tarry stools
Comments S/O		

Genitourinary		
☐ HX Bladder disease	☐ Catheter	☐ Incontinence
☐ Frequency at night	☐ Urgency	
☐ Trouble starting/stopping urine	☐ Pain/burning with urination	
Comments S/O		

Vaginal Problems				
☐ Bleeding	☐ Discharge	☐ Odor	☐ Bulging	☐ Itching
Comments S/O				

Testicular/Prostate Problems
Comments S/O

Musculoskeletal				
☐ Back pain	☐ Falls	☐ Osteoporosis	☐ Joint pain or stiffness	
☐ Engages in physical activities		☐ Changes in activity level		☐ Foot problems
Comments S/O				

Mobility

☐ Fully ambulatory	☐ Ambulatory with assistance	☐ Cane/walker
☐ Prosthesis/appliance	☐ Occasional Wheelchair use	☐ Bed Bound

Gait (if observed):

☐ Ataxia	☐ Unsteady	☐ Poor Balance	☐ Shuffling	☐ Wide Based

Describe need for foot care:

If bed bound describe ROM:

Joint deformity description:

Comments S/O

Neurological

☐ CVA	☐ Numbness in arm, leg or face	☐ Trouble finding words/slurred speech
☐ Paralysis	☐ Headaches	☐ Dizziness
☐ Tremors	☐ Weakness	☐ Seizures

Comments S/O

Psychiatric

☐ Confused	☐ Wanders	☐ Feelings of Depression

☐ Psychiatric HX

☐ Changes in memory

Comments S/O

Endocrine

☐ Diabetes	☐ Insulin Dependent	☐ Controlled Diet
☐ Oral Hypoglycemics	☐ Thyroid Problems	

Comments S/O

Skin

☐ Rash	☐ Dry skin	☐ Itching	☐ Growths
☐ Changes in wart or mole		☐ Wounds/lesions	

☐ Sores that will not heal

Skin characteristics:

☐ Warm	☐ Cool	☐ Dry	☐ Moist	☐ Color

Comments S/O

Vital Signs		
Temperature (optional)	Respiration	
Pulse	BP (indicate position)	
Weight (history or taken)	Height (by history)	
Comments S/O		
Who provided assessment information?		
☐ Client	☐ Caregiver	☐ Family
☐ Other		
Comments S/O		
How reliable is provided information?		
Was this Assessment conducted in the client's home?		
☐ Yes	☐ No (if no, where?)	